U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 July 2007

Case No.: 2006-BLA-00015

In the Matter of

F. R.
Claimant

v.

DOTCO ENERGY CO., INC.
Employer

and

S-I THRU A T MASSEY
C/O UNDERWRITERS SAFETY & CLAIMS
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: JOSEPH WOLFE, Esq.
For the Claimant

NATALIE D. BROWN, Esq.
For the Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was

due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On December 1, 2005, this case was referred to the Office of Administrative Law Judges for a formal hearing (DX 160).[1] Subsequently, the matter was assigned to me. The hearing was held before me in Pikeville, Kentucky, on February 13, 2007, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.[2]

I. ISSUES

The following issues are presented for adjudication:

(1) whether the Claimant has established the irrebutable presumption of total disability, as set forth in § 718.304;
(2) whether the Claimant is totally disabled;
(3) whether the Claimant's total disability, if any, is due to pneumoconiosis; and
(4) whether the Claimant has established a change in a condition or mistake in determination of a fact, pursuant to 20 C.F.R. § 725.310(2000).

II. PROCEDURAL BACKGROUND

The instant matter is the Claimant's third request for modification of a previously denied Claim. The Claimant first filed this claim for benefits on March 4, 1994 (DX 1). On August 16, 1994, the District Director issued a proposed Decision and Order denying benefits, based on a determination that the Claimant had not established that he was totally disabled (DX 19). The Claimant timely requested a formal hearing. A hearing was held before Administrative Law Judge (ALJ) Michael P. Lesniak in April 1996. In a Decision and Order dated October 1996, ALJ Lesniak awarded benefits to the Claimant. In his Decision and Order, ALJ Lesniak found that the Claimant had pneumoconiosis which arose from his coal mine employment and found that the Claimant was totally disabled due to pneumoconiosis, based upon the Claimant's testimony (DX 44).

The Employer timely appealed to the Benefits Review Board (Board) (DX 45). In its appeal, the Employer did not contest ALJ Lesniak's finding that the Claimant had pneumoconiosis arising from coal mine employment, but focused completely on ALJ Lesniak's determination that the Claimant was totally disabled (DX 47). On September 24, 1997, in an unpublished opinion, the Benefits Review Board reversed ALJ Lesniak's Decision and Order (DX 49), holding that it was erroneous as a matter of law for an award of benefits to be made

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T." refers to the transcript of the February 13, 2007 hearing.

[2] The Claimant did not file a post-hearing brief.

based solely on the Claimant's testimony. The Board's Decision did not mention ALJ Lesniak's determination that the Claimant had pneumoconiosis arising from coal mine employment.

In December 1997, the Claimant made his first request for modification of the Board's denial of his Claim (DX 52).[3] A hearing was held before ALJ Robert A. Hillyard in April 1999. In August 1999, ALJ Hillyard issued a Decision and Order denying benefits, finding that the Claimant had not established any mistake in determination of fact and also finding that the evidence was insufficient to establish a change in condition to constitute total disability (DX 79). In his Decision, ALJ Hillyard determined that the Employer was precluded ("collaterally estopped") from raising the issue of whether the Claimant had pneumoconiosis, because the Employer did not raise the issue in its appeal of ALJ Lesniak's award (DX 79 at fn. 1). The Claimant, acting without counsel, appealed ALJ Hillyard's action to the Board (DX 80). However, the Claimant later requested that the Board remand the matter to the District Director to permit him to submit a request for modification; in December 1999, the Board remanded the matter (DX 85).

In January 2000, through counsel, the Claimant made his second request for modification. In February 2001, the District Director granted the modification request and awarded benefits, based on a determination that the Claimant had established that he was totally disabled due to pneumoconiosis; however, the Employer appealed the District Director's determination to the Office of Administrative Law Judges (DX 85).[4]

A hearing was held in May 2002 before ALJ Thomas F. Phalen, Jr. (DX 130). In March 2003 ALJ Phalen issued a Decision and Order denying benefits (DX 136). In his Decision and Order, ALJ Phalen found that the Claimant had not established the irrebutable presumption of total disability under § 718.304, and also had not established that he was totally disabled, as defined in § 718.204. Therefore, determined ALJ Phalen, the Claimant had not established a change in conditions warranting an award of benefits. ALJ Phalen also found that the Claimant had established 23.94 years of coal mine employment, contrary to the 16½ years of coal mine employment that ALJ Hillyard had found, but otherwise did not find any mistake in determination of fact.[5]

The Claimant timely appealed ALJ Phalen's Decision to the Board, and concurrently requested reinstatement of his appeal of ALJ Hillyard's Decision (DX 137). On August 24, 2004, in an unpublished Decision and Order, the Board affirmed ALJ Phalen's and ALJ Hillyard's denials of benefits to the Claimant. In its Decision, the Board affirmed ALJ Phalen's finding that the Claimant had established 23.94 years of coal mine employment, and also

[3] This request for modification was handwritten by the Claimant, who apparently did not have the assistance of counsel at this point in the proceedings.

[4] The Director's Memorandum of Informal Conference indicates that the Claimant was awarded benefits based on the irrebutable presumption of total disability in § 718.304 (DX 85 at 49).

[5] ALJ Phalen specifically noted that "the finding of additional years of coal mine employment does not warrant a review of the entire record to determine the outcome of the claim on the merits" (DX 136 at 24).

affirmed ALJ Hillyard's and ALJ Phalen's determinations that the Claimant had not established any change in condition, nor any mistake in determination of fact.[6]

Subsequent to the Board's Decision and Order, on May 9, 2005, the Claimant submitted his current request for modification of the denial of benefits (DX 149). In support of the request, the Claimant submitted approximately 11 pages of medical treatment records. On August 10, 2005, the District Director denied the Claimant's request for modification, based on his determination that the evidence submitted in support of the modification request "fails to establish a chronic lung disease caused by coal mine employment" (DX 154 at 3).

The Claimant timely appealed the District Director's denial (DX 157), and I presided at the hearing, as set forth above.

The Claimant's current claim was pending on January 19, 2001, the effective date of the amended regulations. See Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended, 65 Fed. Reg. 79920 (Dec. 20, 2000). Consequently, certain sections of the regulations that were in effect when the amended regulations were implemented will apply to the adjudication of this claim. See § 725.2.[7]

III. EVIDENTIARY CONSIDERATIONS

At the hearing, the Claimant objected to my consideration of Employer's Exhibit 2 (EX 2). Employer's Exhibit 2 consists of reports, by Dr. Paul Wheeler and Dr. William Scott, of the Claimant's chest CT scans, taken on November 23, 2004 and March 9, 2005 (T. at 8-10).[8] Citing to the Board's recent Decision in Henley v. Cowin and Co., Inc., B.R.B. No. 05-0788 B.L.A. (May 30, 2006), the Claimant's counsel asserted that the regulations do not allow for rebuttal of hospital or treatment records. The Claimant's counsel acknowledged that this matter was governed by the former version of the regulation, and indicated that he was unsure whether the Henley precedent applied in such circumstances. In response, the Employer's counsel asserted that EX 2 was not a rebuttal of treatment records, but were a "rebuttal or second opinion" with respect to the CT scans. Employer's counsel pointed out that the doctors did not consider hospital records, but rather looked at the actual CT films. In addition, the Employer's position was that the new regulations do not apply retroactively to this claim, but that if I were to find that the regulations did apply, that the Employer would be entitled to at least one interpretation of the CT scans available.

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[6] The Board also noted that ALJ Hillyard had determined that the Employer was "collaterally estopped" from contesting ALJ Lesniak's finding that the Claimant had established that he had pneumoconiosis.

[7] This provision lists the regulatory sections in the amended regulations that are not applicable to pending claims and states that, for those sections, the applicable regulation is the edition of the Code of Federal Regulations, revised as of April 1, 1999. See § 725.2(c). In this Decision, citations to the prior version of the regulation will be denominated with (2000) following the section number. All other citations are to the current version of the Regulation.

[8] This Exhibit also includes the curriculum vitae of Dr. Wheeler and Dr. Scott. The Claimant did not object to my consideration of these items.

Henley involved a claim for benefits filed after January 2001, the effective date of the revised regulations. In Henley, the administrative law judge permitted the employer to rebut an X-ray interpretation contained in medical treatment records the claimant had submitted under § 725.414(a)(4) by submitting one rebuttal reading of the X-ray. The Board held that the administrative law judge erred, because § 725.414 contains no provision for the rebuttal of treatment records, and subsection (a)(4) of that section does not create an exception to the evidentiary limitations for evidence submitted in response to treatment records.

The Board's holding in Henley is consistent with its Decision in Morgan v. Humphrey's Enterprises, B.R.B. No. 05-0308 B.L.A. (Oct. 26. 2005), in which the Board held that an administrative law judge erred by permitting the employer to submit X-ray evidence in response to X-ray interpretations contained in medical treatment records. The Board noted: "There is no direct regulatory authority for the rebuttal of hospitalization and medical treatment records that are received into evidence pursuant to 20 C.F.R. § 725.414(a)(4)." Id., at 4.

As Claimant's counsel recognized, the instant matter involves a claim for benefits filed in 1994, before the amendments to the regulations. In general, the amended version of the regulation applies to claims that were pending in January 2001. See § 725.2. However, § 725.2(c) lists the sections of the amended regulations that do not apply to pending claims. Among those sections is § 725.414. The Board's holdings in Henley and Morgan, which prohibit rebuttal of X-rays admitted as medical treatment records, are based on § 725.414 and its evidentiary limitations.[9]

Under the governing regulation, I also may consider "the results of any medically acceptable test or procedure" which tends to demonstrate the presence or absence of pneumoconiosis, the sequelae of pneumoconiosis or a respiratory or pulmonary impairment. The party submitting the test or procedure has the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's claim to benefits. § 718.107. The Employer did not submit any specific evidence regarding the value of CT scan reports to establish the existence of pneumoconiosis. However, the Board has recognized that CT scans may be of value in Black Lung benefits cases. See generally Melnick v. Consolidation Coal Co., 16 B.L.R. 1-31 (1991)(en banc).

Because CT scan reports have been found to be of value in Black Lung benefits cases and because § 725.414's evidentiary limitations do not apply to claims pending before the amended version of the regulations took effect, I overrule the Claimant's objection to my consideration of EX 2. Therefore, I will consider it in this Decision.

[9] I acknowledge that Henley and Morgan both discuss X-ray interpretations rather than CT scan reports. However, I find that CT scan reports are similar to X-ray interpretations in that both involve a physician's analysis of an objective test.

IV. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in August of 1947. He is married, and has no minor children (DX 1; T. at 22). As set forth in ALJ Phalen's Decision and Order, and affirmed by the Board, the Claimant has a total of 23.94 years of coal mine employment (DX 148). According to his Claim, the Claimant worked in coal production until June 1993, when he was laid off (DX 1). His most recent jobs, in 1992 and 1993, were as a continuous miner operator, section foreman, and equipment operator (DX 2).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. He stated that he was around coal mines for 28 to 30 years. He testified that his first coal mine employment was in 1969, after his discharge from the Army. This employment involved conventional and hand mining underground. The Claimant testified that he became a foreman in 1975 and was a working foreman underground, at the mine face. He stated that he was X-rayed in the NIOSH surveillance program and received a letter from NIOSH. The Claimant testified that he stopped working in June 1993. He stated that he stopped working because he couldn't work any longer, in low coal averaging 38 to 40 inches, because he had a breathing problem. The Claimant stated that his health has gotten considerably worse since he left the mines, and it is worse now that it was five years ago. He said that his shortness of breath is a lot worse, especially with exertion or excitement. When he gets short of breath, the Claimant testified, he also gets dizzy and gets a headache. The Claimant stated that he quit smoking in 1966, when he went into the military (T. at 14-21).

On cross examination, the Claimant stated that he is currently receiving Social Security disability benefits, and said that he has not worked since 1993. He stated that he did not remember that he had testified in the past that he quit working because he was laid off. He indicated that when he was working in the mines he would get a helper if he needed to lift something beyond his capability, but that he did most of his job by himself, and did everything all the time, as a section boss. The Claimant testified that he worked considerable overtime. He stated that he received most of his medical care at the Department of Veterans Affairs facility (T. at 21-23).

Upon my questioning, the Claimant stated that, in addition to his breathing problems, he also has a problem with his sciatic nerve, and he has had the problem for several years. The Claimant also testified that he has some sinus problems. He indicated that he is treated at the Department of Veterans Affairs, and that his lungs and breathing condition are monitored there. The Claimant stated that he is prescribed inhalers, which do not do a lot of good, and is monitored to see how his condition is progressing. He is seen about every four months, on the average (T. at 24-26).

C. Relevant Medical Evidence

In support of the request for modification, the Claimant presented medical records from the Huntington VAMC covering the time period between December 2004 and March 2005; these records included reports of two CT scans, the report of one PET scan, and various treatment notes (DX 149). The Claimant also presented interpretations of chest X-rays of January 13, 2007 (CX 1) and December 2, 2006 (CX 2).

In opposition of the request for modification, the Employer presented medical reports from Dr. Lawrence Repsher, Dr. Kirk Hippensteel, Dr. Gregory Fino, and Dr. Andrew Ghio (EX 1, 4, 5, and 6). The Employer submitted interpretations of CT scans from Dr. Paul Wheeler and Dr. William Scott (EX 2); interpretations by Dr. Wheeler and Dr. Scott of the Claimant's October 4, 2005 X-ray (EX 7); an interpretation by Dr. Wheeler of the Claimant's December 2, 2006 X-ray (EX 8); and Dr. Wheeler's deposition testimony (EX 9). After the hearing, the Employer presented interpretations of the Claimant's January 13, 2007 X-ray by Dr. Wheeler and Dr. Scott (EX 10).

These items will be discussed in greater detail below.

D. Request for Modification

This case pertains to a request for modification of an adverse decision which became final on October 23, 2004, 60 days after the date of the Board's most recent Decision and Order. § 802.406 (DX 148). A request for modification may be made on the grounds of a "change in conditions" or "mistake in determination of fact," at any time within one year after the denial of the claim. § 725.310(a)(2000).

In determining whether a "change in conditions" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against the claimant. Kingery v. Hunt Branch Coal Co., 19 B.L.R. 1-6 (1994). Even if a "change in conditions" is not established, evidence in the entire claim file must be considered to determine whether a "mistake in a determination of fact" was made. This is required even where no specific mistake of fact has been alleged. Kingery, supra.[10]

[10] Prior to the hearing, by Order dated November 6, 2006, I informed the parties that any failure to assert a mistake in determination of a fact prior to the conclusion of the hearing would constitute a waiver of the issue. At the hearing, Claimant's counsel stated that there was a mistake in determination of fact regarding the findings, because the Claimant had progressive massive fibrosis and deterioration. I construe this comment as an assertion that ALJ Hillyard and ALJ Phalen made mistakes in determinations of fact when they found that the Claimant failed to establish that he had complicated pneumoconiosis, as defined in § 718.304, with its attendant presumption of disability. I invited Claimant's counsel to discuss, in the closing brief, any

In this matter the Claimant has alleged a mistake of fact in the determination that the Claimant is not presumptively disabled, and asserts that the Claimant has "progressive massive fibrosis" (T. at 31). Because the Claimant has also alleged a change in conditions, my discussion regarding the issue of mistake in determination of fact is included in my discussion below.

E. Entitlement

The Claimant's entitlement to benefits is evaluated under the regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[11]

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

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additional mistakes in determination of fact in the adjudications of this matter that he had identified (T. at 31-32). Claimant did not submit a post-hearing brief.

[11] The 2001 amendments to the regulations clarify the definition of pneumoconiosis by dividing pneumoconiosis into two types: "clinical" and "legal." § 718.201(a)(2001). The amended definition does not create a new class of entitlement to benefits; rather, it acknowledges a distinction already made by the Circuit courts of appeals in construing the statutory definition. See Campbell v. Consolidation Coal Co., 811 F.2d 802 (6th Cir. 1987). As noted above, this matter is being adjudicated under the former (pre-2001) regulations. However, the current regulatory definition of pneumoconiosis is applicable to such claims. See § 725.2.

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[12]
(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 718.202(a). See Cornett v. Benham Coal Co., 227 F.3d 569, 575 (6th Cir. 2000); Furgerson v. Jericol Mining, Inc., 22 B.L.R. 1-216 (2002)(en banc).

At the hearing, I requested that the parties address in their post-hearing briefs the issue of whether the Employer's purported controversion of the determination that the Claimant has pneumoconiosis presents an issue for my consideration (T. at 27-30).[13] In the post-hearing brief, the Employer asserted that the doctrine of collateral estoppel does not apply in this matter, because that doctrine applies only when there is a prior judgment between the same parties. Rather, the Employer asserted, because all of the litigation in this matter has been on the same claim, and the issue is whether the "law of the case" doctrine applies. The Employer went on to say that the Board recently held that the "law of the case" doctrine generally does not apply in requests for modification. Mitchell v. Daniels Co., BRB No. 03-0134 B.L.A (Feb. 12, 2004)(unpub.).[14] The Employer also argued that all judicially determined facts must be examined de novo in a request for modification, and urged that I reconsider the existence of coal workers' pneumoconiosis in the Claimant as a matter of law.

In Mitchell, the Board stated that "where a request for modification has been properly filed, it is the duty of the second administrative law judge to conduct a de novo review of all the facts in order to determine whether there was a mistake in the judge's determination of fact in the prior decision." Id., at 6. The Board also discussed and reaffirmed the general rule that a stipulation freely entered into by the parties is binding during the course of litigation.

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[12] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[13] I also informed the parties that the Director had submitted a letter indicating that the Director controverted the issue of causation of disability, as well as the issue of the Claimant's total disability (DX 160). The Claimant objected to the Director's late submission of the letter. The Employer was represented by counsel at the hearing. The Director was not present at the hearing.

[14] On further appeal, the Court of Appeals for the Fourth Circuit reversed in part, vacated in part, and remanded the matter. See Daniels Co., Inc. v. Mitchell, 479 F.3d 321 (Mar. 15, 2007). The Circuit Court's decision did not discuss the "law of the case" doctrine.

In this case, the record includes the Employer's recent admissions that the Claimant has pneumoconiosis and that his pneumoconiosis arose at least in part from his coal mine employment. These admissions are contained in Interrogatories that the Claimant's counsel presented to the Employer's counsel; subsequently, the completed Interrogatories were submitted to the District Director (DX 153).[15]

At the hearing before ALJ Lesniak in 1996, the Employer refused to stipulate that the Claimant had pneumoconiosis; however, the Employer acknowledged that the weight of the evidence at that time was that the Claimant had pneumoconiosis, and the Employer anticipated that ALJ Lesniak would so find (DX 40 at 10-11). As noted above, ALJ Lesniak's Decision and Order reflects a determination that the Claimant had pneumoconiosis. On appeal of ALJ Lesniak's award of benefits, the Employer did not contest this finding; rather, the Employer asserted that ALJ Lesniak's award was improper because the Claimant's total disability had not been established (DX 47). It was the Employer's failure to assert any error relating to ALJ Lesniak's finding that the Claimant had pneumoconiosis that let ALJ Hillyard to determine that the Employer was "collaterally estopped" from challenging the issue later.

The Board has held that if a party who is represented by counsel fails to challenge an ALJ's finding on appeal, that finding is deemed conceded. Bucshon v. Peabody Coal Co., 4 B.L.R. 1-608 (1982). The Board also has held that, in general, issues not raised on appeal are conceded.[16] Coen v. Director, OWCP, 7 B.L.R. 1-30 (1984). In addition, the Board has held that its previous affirmance of an issue, during the course of litigation in the same case, is the "law of the case" and is binding on the parties, subject to the limited circumstances under which the law of the case can be disregarded. Brinkley v. Peabody Coal Co., 14 B.L.R. 1-147 (1990); see also Dean v. Marine Terminals Corp., 15 BRBS 394 (1983).

As the Board has noted, the "law of the case" doctrine may not be applicable to Black Lung claims, because the principle of finality does not apply to such claims in the same manner as it does to other types of litigation.[17] Mitchell, supra. In the Sixth Circuit, the major grounds to justify disregard of the law of the case involve an intervening change of controlling law, the availability of new evidence, or the need to correct a clear error or prevent manifest injustice. Cale v. Johnson, 861 F.2d 943 (6th Cir. 1988).

Based on the foregoing, it appears that it is the Employer's position that I now may find that the Claimant does not have pneumoconiosis, based primarily upon my responsibility to re-

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[15] It is not clear, from the record, which party submitted the completed Interrogatories.

[16] The Board has also held that this rule does not apply against a party who did not have an opportunity to contest a matter previously (for example, when an ALJ determines that a Claimant has pneumoconiosis but that benefits should not be awarded because the other elements of entitlement are not established, an employer does not have the opportunity to appeal such a decision). Sellards v. Director, OWCP, 17 B.L.R. 1-77 (1993).

[17] Moreover, it is important to remember that the remedy of the request for modification, under § 725.310(2000) is available to all parties, not just the Claimant. Consequently, the Employer always has the opportunity to challenge the decisions of a fact-finder in a Black Lung case. See, e.g., Branham v. Bethenergy Mines, Inc., 20 B.L.R. 1-27 (1996).

examine the complete record for any mistakes in determination of fact, but also based on the availability of new evidence that, the Employer asserts, calls into question whether the Claimant ever did have pneumoconiosis.

I decline, however, to re-examine the issue of pneumoconiosis simply because of the Employer's request. I note, first, that in conjunction with the Claimant's appeal to the Board of ALJ Phalen's decision, the Employer did not argue that ALJ Phalen's determination that the Claimant had simple pneumoconiosis was in error. Based on the Employer's failure to raise the issue on appeal, the general rule is that the issue is conceded. See Coen v. Director, OWCP, 7 B.L.R. 1-30 (1984).

Second, I find that the Employer's admission regarding the existence of pneumoconiosis, for purposes of this litigation, is binding. See § 725.421(b)(2000). See also Mitchell, supra.

Nevertheless, because I am required to re-examine all the evidence of record to determine whether a mistake in determination of fact has been made, I will discuss the evidence presented on the issue of whether the Claimant has pneumoconiosis.

1) X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis.

The current record contains the following chest X-ray evidence, submitted since the final denial of the Claimant's claim, in August 2004:[18]

[18] In addition, the record contains two interpretations of the Claimant's August 30, 1999 X-ray (EX 3). The two physicians who interpreted the X-ray, Dr. Wheeler and Dr. Scott, both noted that the item presented was a digital copy. There are no NIOSH standards for classification of digital X-rays. See Webber v. Peabody Coal Co., 23 B.L.R. 1-123 (2006)(en banc). Both also noted the item was unreadable (too light). Because the item was deemed unreadable by two Board-certified radiologists, I did not consider it. See Gober v. Reading Anthracite Co., 12 B.L.R. 1-67 (1988).

Date of X-Ray	Date Read	Ex. No.	Physician	Radiological Credentials[19]	Interpretation
10/04/2005	10/04/2005	EX 1	Repsher	B reader[20]	Neg. for pneumoconiosis. Narrative comment: "Reticuonodular extensive infiltrates bilaterally, predominantly at the bases. No paracicatrical emphysema."
10/04/2005	12/14/2006	EX 7	Wheeler	BCR, B reader	ILO: 0/1, q/q?, 4 lung zones (mid and upper). Parenchymal abnormalities consistent with pneumoconiosis questioned. Narrative comments: "…5 cm mass posterior RUL and lower right apex involving pleura and upper oblique fissure and 2-3 cm masses in mid lungs distorting hila and lower lateral left upper lung compatible with conglomerate granulomatous disease, TB or histoplasmosis, more likely than cancer …. Masses are not large opacities of CWP because any subtle small background nodules are in very low profusion."
10/04/2005	Not recorded	EX 7	Scott	BCR[21]	Neg. for pneumoconiosis. Narrative comments: "Bilateral upper lung infiltrates and probable masses (versus confluent infiltrates) most likely granulomatous disease. No background of small, rounded opacities to suggest silicosis/CWP. Histologic

[19] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

[20] The NIOSH certificate appended to Dr. Repsher's curriculum vitae certifies his status as a B reader from 2006 to 2010. However, Dr. Repsher's curriculum vitae states that he was recertified as a B reader in 2002. I presume that this certification covers October 2005 (EX 1).

[21] Dr. Scott's curriculum vitae and the NIOSH certificate appended thereto indicate that he was certified as a B reader through 2004 (EX 2).

					diagnosis should not be difficult to obtain."
12/02/2006	05/02/2007	CX 2	DePonte	BCR [22]	ILO: 2/3, p/r, 6 lung zones. Large opacity Size "B." Coalescence of opacities noted ["ax" block checked].
12/02/2006	12/21/2006	EX 8	Wheeler	BCR, B reader	ILO: 0/1, q/s, 4 lung zones (upper and middle). Parenchymal abnormalities consistent with pneumoconiosis questioned. Narrative comments: "Approximately 7 cm oval mass RUL and lower apex involving upper right hilum and 3 cm mass lower lateral LUL both possibly involving pleura compatible with conglomerate granulomatous disease, histoplasmosis more likely than TB. 3 cm enlargement lower hila compatible with adenopathy or conglomerate masses more likely than dilatation hilar pulmonary arteries. Few few (sic) nodules and linear scars in let (sic) mid lung and lateral LUL and few linear scars in lateral right upper and mid lung with small nodule lower lateral right mid lung compatible with granulomatous disease, TB or histoplasmosis…. Masses are not large opacities because any background nodular infiltrates are very low profusion and he is young. Whatever the disease is, an exact diagnosis is needed to ensure proper therapy and should have been made with biopsy or positive microbiology."
01/13/2007	01/20/2007	CX 1	De Ponte	BCR, B reader[23]	ILO: 2/2, p/r, 6 lung zones. Large opacity size "B".

[22] Dr. DePonte's curriculum vitae, submitted in 2001, appears at DX 98. It reflects that Dr. DePonte was Board-certified in radiology and was certified as a B reader through 2001. In her report of the Claimant's 12/02/06 X-ray, her credentials are listed as "Board-certified radiologist."

[23] Dr. DePonte's curriculum vitae, submitted in 2001, appears at DX 98. It shows that she is Board-certified in radiology and was certified as a B reader through 2001. In her report of the Claimant's 01/13/2007 X-ray, her credentials are listed as "Board-certified diagnostic radiology" and "NIOSH 'B' Reader."

					Coalescence of opacities noted ["ax" block checked]. Narrative comment: "In comparison with 7/13/01 there has been significant progression of the disease."
01/13/2007	03/19/2007	EX 10	Wheeler	BCR, B reader	Neg. for pneumoconiosis. Narrative comments: "Oval partly well defined 8 cm mass RUL and lower right apex between anterior ribs 1-4 probably involving upper right hilum and ill defined cm mass lower lateral LUL between anterior ribs 2-3 involving lateral left hilum compatible with conglomerate granulomatous disease, histoplasmosis more likely than TB. Few tiny linear scars between mass LUL and lateral pleura compatible with healed inflammatory disease ….few small nodules in lateral left mid lung and 1 or 2 in lateral right mid lung or pleura and probably tiny nodule in left lower lateral lung compatible with granulomata…."
01/13/2007	01/20/2007	EX 10	Scott	BCR	Neg. for pneumoconiosis. Narrative comments: "6 cm mass right upper lung. Smaller masses near the hila bilaterally and in the left mid-upper lung. Changes are probably granulomatous disease such as Tb or histoplasmosis unknown activity. No background of small, rounded opacities to suggest silicosis/CWP."

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984).

Where two or more X-ray reports conflict, consideration shall be given to the radiological credentials of the physicians interpreting the X-rays. § 718.202(a)(1). It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder.

Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

For the purpose of determining the X-ray evidence, I give more weight to the opinions of physicians who are Board-certified radiologists and B readers than I do to the opinions of physicians who are not Board-certified radiologists but are B readers. I give more weight to the opinions of the former because they have wide professional training in all aspects of X-ray interpretation. I give equal weight to all physicians who possess the same professional credentials (for example, all Board-certified radiologists).

Discussion

As set forth in the table above, the newly-submitted X-ray evidence consists of interpretations of three X-rays. There are three interpretations of the X-ray of October 4, 2005 (10/4/2005): one from a dually-qualified physician, one from a B reader, and one from a Board-certified radiologist. All interpreted this X-ray as negative for pneumoconiosis. Dr. Wheeler, a dually-qualified physician, noted that there may be some abnormalities consistent with pneumoconiosis. Although Dr. Wheeler has determined that pneumoconiosis may exist, his opinion was not seconded by any other physician. I find, therefore, that the weight of evidence of this X-ray is negative for the disease.

There are two interpretations of the X-ray of December 2, 2006 (12/02/06). Dr. DePonte, a Board-certified radiologist whose status as a B reader at the time she made the interpretation is uncertain, interpreted the X-ray as positive for pneumoconiosis, and also noted the presence of a large opacity in size "B". Dr. Wheeler, a dually-certified physician, noted that there possibly were parenchymal abnormalities consistent with pneumoconiosis.[24] He also stated that the large masses were not pneumoconiosis, based on a low profusion of background nodular infiltrates, and also based upon the Claimant's relatively young age.[25] Based on the fact that two highly-qualified experts concur that there may be evidence of pneumoconiosis on this X-ray, I find that the weight of the evidence regarding the December 2, 2006 X-ray is positive for the presence of pneumoconiosis.

[24] He also discussed this conclusion in his deposition testimony. See, e.g., EX 9 at 29.

[25] I will discuss the issue of whether the Claimant has established the existence of large opacities later in this Decision.

The record contains three interpretations of the X-ray of January 13, 2007, two from dually-qualified physicians and one from a Board-certified radiologist. As before, Dr. DePonte, who is dually-qualified, interpreted this X-ray as positive for pneumoconiosis, and she also interpreted it as containing a large opacity in size "B." Dr. Wheeler, a dually-qualified physician, interpreted the film as negative for pneumoconiosis. He commented again about the large masses and stated that they were compatible with other diseases (histoplasmosis more likely than tuberculosis). Dr. Scott, a Board-certified radiologist, interpreted the X-ray as negative for pneumoconiosis and also interpreted the large masses as evidence of diseases other than pneumoconiosis. Dr. Scott also commented that there was "no background of small, rounded opacities" to suggest pneumoconiosis. Although there appears to be some evidence that this film shows evidence of pneumoconiosis, I find that the weight of the evidence of this film is negative for the disease.

Taken as a whole, the newly-submitted evidence X-ray evidence does not establish, by a preponderance of evidence, that the Claimant has pneumoconiosis. However, this evidence is not inconsistent with the evidence developed in this case to date regarding the issue of whether the Claimant has simple coal workers' pneumoconiosis. Of the medical experts who provided interpretations of the newly-submitted X-rays, only Dr. Repsher and Dr. Scott indicated that there was no evidence of the disease. I give Dr. Repsher's interpretation less weight than I give to the other interpretations, because Dr. Repsher is a B reader, but not a radiologist, and his experience interpreting X-rays for a variety of lung abnormalities is presumed to be less broad than that of a specialist. I give Dr. Scott's interpretation due weight based on his professional credentials; however, where Dr. Wheeler concludes that there may be some opacities indicative of simple coal workers' pneumoconiosis present, Dr. Scott states that there are none. Based on the Claimant's past X-rays, where simple coal workers' pneumoconiosis has been diagnosed in a vast majority of instances, it is likely that Dr. Wheeler's conclusion is more probable than Dr. Scott's. Consequently, I give less weight to Dr. Scott's interpretations.

Considering the X-ray evidence as a whole, both the evidence newly submitted and the evidence previously submitted, I find that the weight of the evidence, which includes positive X-rays dating back to 1994, establishes, by a preponderance of evidence, that the Claimant has pneumoconiosis.[26]

Medical Treatment Records and Other Medical Evidence[27]

As stated above, the parties submitted additional evidence with regard to the Claimant's request for modification. The Claimant's submission, which he characterized as medical treatment records, consists of reports of two CT scans and one PET scan of the Claimant's lungs,

[26] ALJ Phalen's Decision summarized this X-ray evidence in detail (DX 136).

[27] The Board has instructed that CT test results should not be evaluated as "X-ray evidence" but rather as "other medical evidence" under § 718.107. See Harris v. Old Ben Coal Co., 23 B.L.R. 1-98 (2006). I have placed the discussion of the Claimant's medical treatment records here in my Decision because several of the physician opinions, discussed below, refer to the CT scan and PET test results.

as well as several pages of treatment notes from Dr. Nancy Munn (DX 149). The Employer submitted additional interpretations of the Claimant's CT scan (EX 2).

The Claimant's medical treatment records indicate that he underwent CT scans on 11/23/04 and 3/09/2005, while under Dr. Munn's care. The purpose for these tests, according to the records presented, was to rule out lung cancer. The medical orders for the CT tests reflect that the Claimant had previously been diagnosed with coal workers' pneumoconiosis.

The CT scan of 11/23/204 was compared with a prior image, dated 08/30/99.[28] It included the following findings, reported by Dr. Barbara Lahr: "Significant interval worsening in appearance of the chest is noted …. Innumerable nodules are noted with upper lobe predilection measuring up to 1.2 cm in size bilaterally….Interstitial nodular pattern is again noted bilaterally with prominence in the upper lobes …. Impressions included the following: "New mass-like densities are noted in bilateral upper lobes (right greater than left). These could reflect coalescence of masses, particularly given bilateral nature, or new masses ….findings may reflect inflammatory process … or neoplastic process. Dr. Munn's impressions are recorded as follows: "In view of occupational exposure history, I would wonder if this represents a pneumoconiosis picture with consideration for progressive massive fibrosis. This is especially true as there has been progression over a 6-7 year period. However, cannot exclude malignancy as an etiology….Offered PET scan for further information but told [the Claimant] this would not give a definitive diagnosis ….dyspnea probably related to pneumoconiosis."

The PET scan report of 02/15/2005, interpreted by Dr. Rick Compton, included the following findings: "Prominence (sic) foci of abnormal FDG uptake within both upper lobes, the larger area noted on the right measuring 6.8 cm in cephalocalaudad extent by 4.7 by 2 cm in size…. This corresponds with fairly confluent somewhat lobular appearing area of mass-like consolidation seen on CT …. There are smaller foci of hypermetabolic activity seen within the adjacent lung parenchyma corresponding with peripheral nodularity seen on CT." Dr. Compton's conclusions included the following: "Malignancy must be considered. Based upon the CT appearance other etiology including progressive massive fibrosis could also be considered."

The CT scan report of 3/09/2005, interpreted by Dr. George Wilson, included the following findings: "Spiculated mass densities are again seen in both upper lobes….lung bases are grossly clear." His Impression included the following: "No significant interval change. Differential diagnosis remains the same. While these changes may simply represent massive fibrosis associated with the patient's pneumoconiosis, a neoplastic process cannot be completely excluded….".

Dr. Munn's treatment notes, from February 2005, note that the Claimant has dyspnea on exertion and has only occasional cough and sputum production. She noted no pulmonary abnormalities on examination. She recorded that the Claimant worked about 30 years in mining and did not wear a mask or respirator, that he had a positive PPD test [for tuberculosis] but was never treated, and was exposed to TB as a child.

[28] Presumably, this is the same X-ray referred to above. See fn. 18.

The Employer presented interpretations of the Claimant's two CT scans from Dr. Paul Wheeler and Dr. William Scott (EX 2). Both of these physicians are Board-certified radiologists. Regarding the Claimant's November 23, 2004 CT scan, Dr. Wheeler observed "irregular 5 cm mass posterior RUL and right apex and lobulated 3 cm mass lower lateral LUL compatible with conglomerate granulomatous disease more likely than cancer…" He also noted many other nodular infiltrates and small masses, compatible with histoplasmosis, tuberculosis, or inflammatory disease. Lastly, Dr. Wheeler stated "few small nodules in this case could be CWP but granulomatous disease with conglomerate masses, pleural involvement and minimal adenopathy are best explained by granulomatous disease, TB or histoplasmosis." Regarding this CT scan, Dr. Scott stated: "5 cm right upper lobe mass. 3 cm left upper lobe mass. Few scattered nodules of smaller size. 1 cm calcified granuloma anterior right mid-lung....These changes are most likely due to TB, unknown activity or other granulomatous disease."

Regarding the Claimant's March 9, 2005 CT scan, Dr. Wheeler wrote: "Mass in posterior RUL and lower right apex and mass in lower lateral LUL, both involving pleura, compatible with conglomerate TB or histoplasmosis ….He is quite young to have CWP and large opacities. NIOSH began controlling dust levels in mines in the early 1970s and large opacities have been quite rare since WW2 when drillers had no respiratory protection." Regarding this scan, Dr. Scott wrote: "No significant change since exam 11/23/04. 5 cm mass right upper lung and 3 cm mass slightly lower in left lung. Additional smaller nodules of varying sizes. Few calcified granulomata. Bilateral hilar and mediastinal adenopathy. Changes are probably TB, unknown activity, or other granulomatous disease."

2) Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

3) Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, defined as one or more large opacities greater than one centimeter in diameter on X-ray, which would be classified as category A, B, or C opacities in the ILO-U/C classification scheme. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978.

Discussion

There is some evidence in this matter that the Claimant may have complicated pneumoconiosis. The X-ray interpretations by Dr. Kathleen DePonte of the Claimant's X-rays of 12/02/2006 and 1/13/2007 reflect Category B opacities (CX 1, 2). However, the Employer submitted evidence from other Board-certified radiologists regarding the same X-rays; these

interpretations surmised that the Claimant did not have any large opacities: indeed, Dr. Wheeler and Dr. Scott stated that these X-rays did not reflect pneumoconiosis at all but rather reflected other diseases, such as histoplasmosis, tuberculosis, or granulomatous disease (EX 8, 10).

Under the regulation, a Claimant who has large opacities, one (1) centimeter in diameter or greater, equating to size "category A" or greater under the ILO standards, as observed on X-ray, has complicated pneumoconiosis. For such a Claimant, an irrebutable presumption of total disability due to pneumoconiosis applies. § 718.304(a). However, the presumption that the Claimant is totally disabled due to complicated pneumoconiosis does not apply unless the Claimant establishes, by a preponderance of evidence, that he has complicated pneumoconiosis. Harris v. Old Ben Coal Co., B.R.B. 04-0812 B.L.A. (Jan 27, 2006)(en banc); see also Gray v. SLC Coal Co., 176 F.3d 382 (6th Cir. 1999). The United States Court of Appeals for the Sixth Circuit has held that "[x]-ray evidence of opacities larger than one centimeter does not automatically trigger the irrebuttable presumption when conflicting evidence exists." Gray, supra, at 388. The Board has stated that an opacity greater than one centimeter, which would be classified as size A, B, or C, establishes complicated pneumoconiosis unless there is affirmative evidence that establishes persuasively either that the opacity does not exist or that it is the result of a disease process not related to an exposure to coal mine dust. O'Dell v. Consolidation Coal Co., B.R.B. No. 03-0159 (Oct. 31, 2003).

Here, the evidence of complicated pneumoconiosis is in conflict. I must resolve the conflicting evidence to determine whether the Claimant has established, by a preponderance of evidence, that he does indeed have complicated pneumoconiosis. Atkins v. Westmoreland Coal Co., B.R.B. No. 02-0877 B.L.A. (Sept. 9, 2003); see also Keene v. G & A Coal Co., Inc., B.R.B. No. 96-1689 B.L.A.-A. (Sept. 27, 1996). The Claimant has presented little evidence, other than X-ray interpretations and CT scan reports, to establish that he has complicated pneumoconiosis. The Employer's evidence in opposition consisted primarily of interpretations, by other physicians, of the same X-rays and CT scans.

I have discussed the X-ray evidence above. Regarding the CT scan evidence, the Claimant presented opinions from Dr. Barbara Lahr and Dr. George Wilson. These opinions indicate that these physicians observed large masses (greater than one centimeter) and considered whether the Claimant had progressive massive fibrosis.[29] Both of these may be indicia of complicated pneumoconiosis, as defined in § 718.304. The Employer presented evidence from two Board-certified radiologists, Dr. Paul Wheeler and Dr. William Scott. Both observed large masses, exceeding one centimeter in diameter, in the Claimant's lungs. Both, however, opined that these large masses were caused not by pneumoconiosis but by other diseases – histoplasmosis or tuberculosis or an unspecified granulomatous disease.[30]

[29] I note that the physicians' opinions regarding progressive massive fibrosis are somewhat equivocal, as the physicians also discuss whether the Claimant's masses are cancerous. I presume that the Claimant did not have lung cancer, as the record contains no evidence he was diagnosed with cancer or is under treatment for cancer.

[30] Dr. Scott's assessment is not inconsistent with his interpretations of the Claimant's 2001 and 2002 X-rays. See DX 113, 124.

The record establishes that there is a clear consensus that the Claimant has at least two lung masses with diameters of more than one centimeter. However, as set forth above, there is disagreement as to the cause of these masses, with the Claimant's physicians citing pneumoconiosis and the Employer's physicians citing other causes.

The record does not contain any information about the professional qualifications of the physicians whose reports the Claimant cites. I am unable, therefore, to assess the credibility of these physicians' opinions, particularly when weighing their opinions against the opinions of Board-certified radiologists submitted by the Employer. In this regard, I find that, in general, the opinions of Board-certified radiologists regarding the interpretation of CT scans should be weighed more heavily than the opinions of physicians whose credentials are not known.

In this matter, however, I give less weight to Dr. Wheeler's opinion regarding the etiology of the Claimant's large lung masses, for two reasons. First, as his deposition testimony demonstrates, Dr. Wheeler presumed that the Claimant had a history of 16 years of coal mine employment, not the more than 23 years of employment that is established. The Claimant's exposure to coal mine dust was about 50% more than Dr. Wheeler presumed. It is possible that Dr. Wheeler's opinion might have been affected, had he known the actual amount of the Claimant's dust exposure. Second, Dr. Wheeler's comment regarding causation of complicated pneumoconiosis based on coal mine industry practices is inconsistent with the regulatory mandate. The governing regulation recognizes that any miner can develop large opacities, and also does not limit determinations of complicated pneumoconiosis to miners of advanced age or miners who worked in certain types of employment.

Consequently, based primarily on the opinions of Dr. Scott, and to a lesser extent Dr. Wheeler, which call into question the CT evidence presented by the Claimant that he has complicated pneumoconiosis, I find that the CT scan evidence does not establish that the Claimant's large lung masses are due to pneumoconiosis.[31]

The Claimant also presented treatment notes from Dr. Nancy Munn, which record her assessment that the Claimant may have progressive massive fibrosis, as well as a PET scan report from Dr. Rick Compton, which makes the same conclusion. The Employer has not presented any evidence rebutting these two items of evidence. I presume that Dr. Munn is a treating physician, and so I have considered her opinion as required under § 718.104. However, the record does not contain information regarding the treatment relationship between Dr. Munn and the Claimant that would permit me to give controlling weight to her opinions, as suggested by § 718.104(d)(1)-(4).[32] Moreover, the record is scanty regarding Dr. Munn's professional

[31] I note that Dr. Wheeler's report of the November 23, 2004 CT scan includes a comment that he has observed opacities that "could be CWP" and find that this constitutes evidence of simple coal workers' pneumoconiosis.

[32] At DX 85, there is a one paragraph statement from Dr. Munn, dated January 2000, which states that the Claimant "has been seen" for pulmonary problems. The statement is on the letterhead of the Department of Veterans Affairs Medical Center in Huntington, WV, and Dr. Munn's signature block states that she is the "Chief, Pulmonary Section." Her statement does

qualifications, so I am unable to weigh her conclusion in light of any specific professional expertise. In any event, Dr. Munn's opinion is somewhat equivocal. Therefore, I give her opinion little weight. Similarly, Dr. Compton's opinion is equivocal and conclusory; in addition, the record contains no information about his professional qualifications. Consequently, I give his opinion little weight as well.

Weighing together all the newly-submitted evidence presented, including the X-ray evidence discussed above, I find that the Claimant has not established, by a preponderance of evidence, that he has complicated pneumoconiosis, as defined in § 718.304. Weighing the newly-submitted evidence in conjunction with the evidence previously submitted, including the X-ray evidence, I find that the Claimant has not established that he has complicated pneumoconiosis. I concur with the findings of ALJ Phelan, who determined that the Claimant has indeed presented some evidence of complicated pneumoconiosis. However, in light of the evidence that the large masses in the Claimant's lungs are not due to pneumoconiosis but instead are the result of a different disease process, the evidence the Claimant has presented is insufficient to establish, by a preponderance of evidence, that he has complicated pneumoconiosis. Consequently, the existence of pneumoconiosis is not established under § 718.202(a)(3). See Melnick v. Consolidation Coal Co., 16 B.L.R. 1-31 (1991)(en banc); O'Dell v. Consolidation Coal Co., B.R.B. No. 03-0159 B.L.A. (Oct. 31, 2003).

4) Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions, submitted after the final denial of the Claimant's claim, in August 2004:[33]

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not indicate that the Claimant is a patient of Dr. Munn or relate how often he has been treated (DX 85 at 146).

[33] Because this matter was pending in January 2001, when the evidentiary limitations of § 725.414 were instituted, the regulatory limits of that section do not apply. See § 725.2.

Dr. Lawrence Repsher (EX 1)

At the request of the Employer, Dr. Repsher, who is Board-certified in internal medicine, pulmonary disease and critical care medicine and is a B reader, conducted a consultative examination of the Claimant in October 2005, and submitted a written report in November 2005. Dr. Repsher's evaluation consisted of a physical examination, the taking of a medical and work history, and various medical tests, including a chest X-ray and an arterial blood gas test.[34] The report reflects that Dr. Repsher considered a coal mine employment history of 28 years, with the Claimant's last position as a section boss, and also considered a smoking history of one year, ending in 1966. Dr. Repsher's report also reflects that he examined the Claimant in the past.[35]

In his report, Dr. Repsher noted that the Claimant appeared dyspneic with only mild exertion. Dr. Repsher noted an elevated blood pressure, but did not note any abnormalities of the lungs on physical examination. In his "Impressions," Dr. Repsher stated that there was no evidence of medical or legal coal workers pneumoconiosis, and no evidence of any other pulmonary or respiratory disease or condition. He stated that, based on the Claimant's X-rays, tuberculosis or histoplasmosis might be considered, but he did not explain how the Claimant's negative TB skin test from two years earlier, which he noted, before might affect that analysis. The reasons for Dr. Repsher's opinion included that the Claimant had no radiographic, histologic, or pulmonary function test evidence of pneumoconiosis. Dr. Repsher noted that the Claimant had hypertension and probable diabetes, and also had symptoms of left ventricular congestive heart failure and peripheral vascular disease of both lower extremities. Dr. Repsher noted that the Claimant's hypoxia, which was not qualifying for disability, has been intermittent, and has occasionally been within normal limits, which suggested that the Claimant's hypoxia is not due to pneumoconiosis. Dr. Repsher stated that the Claimant's X-rays showed evidence of granulomatous disease, but was not consistent with pneumoconiosis.

Dr. Kirk Hippensteel (EX 4)

At the request of the Employer, Dr. Hippensteel, who is Board-certified in internal medicine, pulmonary disease and critical care and is a B-reader, reviewed various records relating to the Claimant and submitted a written report dated June 2006. Dr. Hippensteel's report, which focuses on evidence developed from 2002 onward, reflects that he examined the Claimant in March 2000 and wrote several earlier reports.[36] Among the items Dr. Hippensteel reviewed were Dr. Munn's treatment notes, which the Claimant had submitted support of his request for modification. These notes indicated that the Claimant had a past positive TB skin test (PPD) and that he had been exposed to tuberculosis as a child (DX 149).

[34] According to Dr. Repsher's report, the Claimant declined a pulmonary function test, because past tests caused dyspnea and chest pain, and also declined a CT scan.

[35] Dr. Repsher's last report, dated April 2002, is at DX 125. At that time, Dr. Repsher stated that the Claimant's X-ray may show evidence of simple coal workers' pneumoconiosis, but seemed atypical for that disease, and that chronic granulomatous disease should be considered.

[36] Dr. Hippensteel's earlier reports are at DX 93, 109, 115, 117, 124.

Dr. Hippensteel concluded, based on his review of X-ray interpretations, CT test reports, and reports from various physicians, that the Claimant has granulomatous disease, and not coal workers' pneumoconiosis. His report stated: "I would note that there is a similarity in appearance that can occur between simple pneumoconiosis and granulomatous disease because both cause rounded opacities. It becomes more clear that granulomatous disease is a cause when there are calcified granulomas present, which is not a part of coal workers' pneumoconiosis. Granulomatous disease and coal workers' pneumoconiosis can produce conglomerate opacities, but the features of these opacities in this man strongly favor granulomatous disease as noted by the experts above who interpreted his X-rays and chest CT scans."

Dr. Gregory Fino (EX 5)

At the request of the Employer, Dr. Fino, who is Board-certified in internal medicine and pulmonary disease and is a B reader, reviewed records related to the Claimant and submitted a written report in June 2006 (EX 5). His previous report, which concluded that the Claimant had simple coal workers' pneumoconiosis without impairment or disability, was rendered in April 2002 and is in the record at DX 126.[37]

In his most recent report, which focused on evidence obtained in 2002 and later, and which indicated that he reviewed the Claimant's CT scan and PET scan reports, as well as X-ray interpretations from 1999 and 2002 and Dr. Repsher's November 2005 report, Dr. Fino stated that he would not change any of his conclusions.

Dr. Andrew Ghio (EX 6)

At the request of the Employer, Dr. Ghio, who is Board-certified in internal medicine and pulmonary medicine and is a B reader,[38] reviewed medical records related to the Claimant and, in June 2006, submitted a written report. The records Dr. Ghio reviewed covered the period between 1990 and 2005, and included Dr. Repsher's November 2005 report, as well as the Claimant's recent CT and PET scans.

Dr. Ghio observed that the Claimant had numerous X-ray interpretations that were positive for pneumoconiosis, but also noted that the Claimant's recent CT and PET tests, as interpreted by Dr. Wheeler and Dr. Scott, supported a diagnosis of tuberculosis, histoplasmosis, or other granulomatous disease. Dr. Ghio stated: "Their opinions must be provided a greater value as a result of their experience. Therefore, it should be concluded that [the Claimant] does not have coal workers' pneumoconiosis but rather has a granulomatous disease such as tuberculosis or histoplasmosis." Dr. Ghio also concluded that the Claimant did not have "legal pneumoconiosis" because his lung function, as measured by pulmonary function tests and arterial blood gas tests, was normal.

[37] Earlier reports from Dr. Fino are at DX 87, 115, and 117.

[38] Dr. Ghio's curriculum vitae also reflects that he is Board-eligible in occupational medicine.

Dr. Paul Wheeler (EX 2, 3, 7, 8, 9, 10)

As listed above, the Employer submitted interpretations of the Claimant's X-rays, CT scan, and PET scan from Dr. Wheeler, who is dually qualified as a Board-certified radiologist and a B reader. The Employer also submitted the transcript of Dr. Wheeler's deposition (EX 9).[39]

In his deposition, Dr. Wheeler testified that he has many years of experience as a radiologist, and that his current practice focuses on radiology of the chest. He testified that a CT scan is the "gold standard" for detecting interstitial disease of the lungs of any sort, but histology is still required to give an exact diagnosis. Dr. Wheeler stated that he reviewed and interpreted a series of X-rays and CT scans of the Claimant's lungs, dated between 1999 and 2006. He testified that the earliest X-ray, from 1999, showed "mixed irregular and nodular infiltrates," but there was no mention of a mass and the pattern was asymmetrical. In his opinion, tuberculosis was a likely diagnosis.[40] Dr. Wheeler also stated that later on, a mass developed, which indicated that the disease process was evolving; he remarked that in his experience large opacities do not develop unless people have ongoing occupational exposure.

Dr. Wheeler also testified that the CT scans confirmed there was a calcified granuloma in the right middle lobe, and he discerned that this was either histoplasmosis or tuberculosis. He stated that CT scans are more sensitive than regular X-rays and thus will pick up calcified granulomas, whereas X-rays may not.

Regarding his other X-ray interpretations, Dr. Wheeler testified that in some of them he noted a profusion of small opacities, which he marked as 0/1 or 1/0, which is a minor difference. In the X-ray of March 21, 2000, Dr. Wheeler stated, he marked 2/3, and he put question marks all over the place because he was aware the pattern could be silicosis or tuberculosis. Dr. Wheeler testified that he thought some of the nodules could be simple coal workers' pneumoconiosis but the masses were not, for several reasons, one of which was that the small nodules were not of sufficient profusion to cause the large opacities. He stated that on one of the Claimant's X-rays, he put a question mark next to the B opacity designator, which meant that if the opacity were present it would be a B size opacity. However, in his experience, B size opacities are quite rare after World War II, because NIOSH and MSHA became quite active after the Coal Mine Safety and Health Act of 1969.

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[39] The Claimant did not object to my consideration of Dr. Wheeler's deposition (T. at 12). This matter is governed by the former version of the regulations, and the evidentiary limitations of § 725.414 do not apply. Therefore, I find that the Board's recent guidance, that this section of the regulation does not permit physicians who submitted X-ray interpretations or other objective test results to testify by deposition, to be inapplicable, and therefore I will consider Dr. Wheeler's testimony. See Tapley v. Bethenergy Mines, Inc., B.R.B. No. 04-0790 B.L.A. (May 26, 2005).

[40] On page 22 of the deposition Dr. Wheeler stated that this X-ray was from 1998, but he earlier stated (on page 19) that the X-ray was from 1999. The Exhibit appended to the deposition transcript reflects that the X-ray was taken on August 30, 1999.

Dr. Wheeler stated that a CT scan is a good technique for determining the absence or presence of complicated pneumoconiosis, because it can show when a mass involves the pleura, which is strong evidence of granulomatous disease or cancer. It can also show calcified granulomata not visible on routine chest X-rays.

Dr. Wheeler stated that the Claimant's CT scans showed a mass in the posterior right upper lobe and lower right apex and a mass in the lower lateral left upper lobe. Both involved the pleura and were compatible with conglomerate TB or histoplasmosis. There were other nodules consistent with calcified granulomata. The two CT scans showed a stable pattern, which tended to indicate that the Claimant did not have cancer or an active ongoing infection, because then there would be progression. Dr. Wheeler again stated that some of the small nodules could be coal workers' pneumoconiosis, but granulomatous disease could also explain the findings best.

Dr. Wheeler testified that patients who develop tuberculosis or histoplasmosis know they are sick, with a fever or cough perhaps. However, the vast majority of histoplasmosis cases are self-cured. When tuberculosis causes masses, it typically requires some form of therapy or it will progress to death. Consequently, Dr. Wheeler stated, he presumed that the Claimant had histoplasmosis, and he stated that the mass lesions, in his opinion, were conglomerate histoplasmosis.

Upon being asked whether the Claimant had sufficient coal dust exposure to cause coal workers' pneumoconiosis, and being asked to presume that he had 16 years of exposure, Dr. Wheeler responded that the Claimant had his exposures in the years when NIOSH and MSHA were proactively guarding dust levels in mines, and in any case it was Dr. Wheeler's experience that drillers were most likely to get large opacities.

On cross-examination, Dr. Wheeler reiterated that a diagnosis could be definitively done with a biopsy. He also stated that he sees many people who have large lung masses, because of his experience with the Baltimore tuberculosis clinic, and that he presumes the Claimant has granulomatous disease, but no one can be certain without a biopsy. Dr. Wheeler stated that histoplasmosis is endemic in the mining areas of the Midwest, in the Ohio River Valley, possibly in the Tennessee River Valley, and is also endemic in Europe. It is much more common in the Ohio River Valley and Tennessee River Valley, which have a lot of mining areas. From the X-rays he examined, Dr. Wheeler stated, it appeared that the Claimant had large opacities in his lungs from 2000 on. Dr. Wheeler commented that the Claimant's X-ray showed an asymmetrical pattern, which was not typical, because inhaled particles tend to deposit in the lungs in a symmetrical way.

On re-direct examination, Dr. Wheeler stated that he was well aware of the masses in the Claimant's lungs, and would have preferred that the Claimant be diagnosed by a scientific method rather than X-rays and CT scans.

Discussion

In brief, the new evidence presented consists of five physician opinions, all from the Employer, plus Dr. Munn's treatment notes, summarized above. Of these, only Dr. Munn and Dr. Fino concluded unequivocally that the Claimant has pneumoconiosis. Dr. Wheeler stated in his deposition testimony that it is possible that the Claimant has coal workers' pneumoconiosis, based on his observation of small nodules in the CT scans. Dr. Repsher, Dr. Hippensteel, and Dr. Ghio concluded that the Claimant does not have coal workers' pneumoconiosis, but opined that the Claimant has X-ray evidence of some other disease (histoplasmosis, tuberculosis, etc.), consistent with Dr. Wheeler and Dr. Scott's CT recent scan interpretations.

Dr. Repsher's conclusion is not inconsistent with his previous opinion, which stated that a different X-ray was atypical for pneumoconiosis, and which opined that the Claimant did not have the disease (DX 125). Dr. Hippensteel previously opined that the Claimant had simple coal workers' pneumoconiosis, but does not state this in his current assessment. He does note that granulomatous disease can cause opacities similar to pneumoconiosis. Dr. Ghio's opinion is based primarily on Dr. Wheeler's and Dr. Scott's CT scan reports.

I give little weight to Dr. Hippensteel's and Dr. Ghio's opinions. They seem to derive their opinions primarily from the Dr. Wheeler's and Dr. Scott's assessments of the large masses in the Claimant's lungs. Tellingly, their opinions do not reflect whether they considered the possibility that, although the Claimant's large masses may not be pneumoconiosis, he still may have the disease. Moreover, I find that Dr. Hippensteel's opinion is not well-reasoned, because he does not explain why his previous opinion, which unequivocally stated that the Claimant has simple coal workers' pneumoconiosis, is wrong.

I give some weight to Dr. Repsher's opinion, which is not inconsistent with his previous opinion that the Claimant most likely did not have pneumoconiosis. However, Dr. Repsher's opinion is offset by Dr. Fino's opinion. Dr. Fino's most recent opinion reflects that he reviewed the most recent data, including Dr. Wheeler's and Dr. Scott's CT scan reports, and he did not change his conclusion that the Claimant has pneumoconiosis. However, Dr. Fino does not explain the basis for his conclusion, so I do not give much weight to his conclusion. Likewise, Dr. Munn's treatment notes are scanty; her primary reference for her conclusion appears to be historical (prior X-rays).

Considering only the newly-submitted evidence from physician opinions, I find that this evidence casts significant doubt upon whether the large masses in the Claimant's lungs are pneumoconiosis lesions. The professional opinions of Dr. Scott and, to a lesser extent, Dr. Wheeler, suggest that these masses are caused by a different disease process. However, this conclusion does not necessarily exclude the possibility that the Claimant also has simple pneumoconiosis. I find, therefore, that the weight of the newly-submitted evidence establishes that the Claimant has pneumoconiosis. Taken in conjunction with all of the evidence compiled

in this matter to date, including (but not limited to) physician opinions, I find that the Claimant has established, by a preponderance of evidence, that he has pneumoconiosis.[41]

The Employer's brief urges that I reconsider the issue of whether the Claimant has pneumoconiosis. The Employer implies that the newly-submitted evidence, in particular the CT scan reports, establish that the Claimant does not currently have pneumoconiosis, but rather has some other lung disease such as histoplasmosis or tuberculosis. Consequently, asserts the Employer, even though the Claimant previously established that he had pneumoconiosis, I should now find that the Claimant has not established that element of entitlement.

As set forth above, I have declined to assess this issue, based on the procedural posture of this case. However, even presuming that there is no procedural bar to my examination of the issue, I am required to assess the newly submitted evidence to determine whether there is a mistake in determination of a fact. Notably, newly discovered evidence may also constitute a rationale for not adhering to the "law of the case" doctrine. See Cale v. Johnson, 861 F.2d 943 (6th Cir. 1988).

Based on the totality of the evidence submitted in connection with the Claimant's request for modification, as noted above, I find that the total weight of all of the evidence, including the CT scan reports, establishes that the Claimant does not have complicated pneumoconiosis, as defined in § 718.304. However, I also find that the evidence does not demonstrate that the previous establishment of the fact that the Claimant has simple pneumoconiosis is wrong. Consequently, I also find that there is no mistake in determination of fact in this matter, based on the record before me.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). In this case, the record establishes that the Claimant has 23.94 years of coal mine employment. Therefore, he is entitled to the rebuttable presumption.

The Employer has not presented any evidence to rebut this presumption.[42] I find, therefore, that the Claimant has established, by a preponderance of evidence, that his pneumoconiosis arose from his coal mine employment.

c. Whether the Claimant is Totally Disabled

As noted above, I have found that the Claimant has not established the irrebuttable presumption of total disability under § 718.304. Consequently, the Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section

[41] ALJ Phalen's Decision summarized the physician opinions already included in the record (DX 136).

[42] As noted above, the CT scan reports and physician opinion evidence the Employer has submitted do not rebut the Claimant's establishment of the existence of pneumoconiosis.

718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

1) Pulmonary Function Tests

A Claimant may establish total disability based upon pulmonary function tests. ALJ Phalen found that the Claimant was unable to establish total disability based on pulmonary function test results, because the pulmonary function tests submitted did not have qualifying values. The record contains no pulmonary function tests administered after August 2004. I find, therefore, the Claimant is unable to establish, by means of pulmonary function test results, that he is totally disabled.

2) Arterial Blood Gas Tests

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

ALJ Phalen found that the arterial blood gas tests the Claimant submitted did not have qualifying values and therefore, the Claimant could not establish total disability by means of arterial blood gas test results.

The record contains the following arterial blood gas test results, administered since the Board's Decision in August 2004:

Date of Test	Physician	PCO_2	PO_2	Altitude
10/04/2005	Repsher	36.3	70.0	<2999 ft.

* Post-exercise trials not performed.

For a PCO_2 value of 36.3, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 63. Based on the foregoing, where the sole arterial blood gas test did not register a qualifying value, I find that the Claimant is unable to establish total disability under this provision.

3) Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). Although the Claimant has established that he has pneumoconiosis, the record contains no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

4) Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

In his Decision, ALJ Phalen noted that the Claimant had submitted no new physician opinion evidence regarding total disability, and that the evidence the Employer submitted on the issue, from several different physicians, consistently indicated that the Claimant was not totally disabled, from a respiratory perspective.

In the current request for modification, the Claimant has not submitted any new physician opinions on the issue of total disability. The Employer has submitted physician opinions as follows:

a) Dr. Repsher stated that, because there was no pulmonary impairment, from a respiratory point of view the Claimant remained fully fit to perform his usual coal mine work (EX 1).

b) Dr. Hippensteel stated that the additional records he reviewed do not show significant impairment in function that would keep the Claimant, from a pulmonary standpoint, from working in the mines, even if the Claimant did have pneumoconiosis (EX 4).

c) Dr. Ghio stated that the Claimant's pulmonary function tests were normal; based on these tests, therefore, the Claimant was "able to do regular coal mining work or work requiring a similar effort." Dr. Ghio also opined that even if the Claimant were diagnosed with coal workers' pneumoconiosis, he has no respiratory impairment (EX 6).

Upon consideration of these opinions, I find that the Claimant has not established that he has a respiratory or pulmonary impairment based on physician opinion.

Upon consideration of all of the evidence relating to the issue of disability, including the evidence adduced prior to the Claimant's current request for modification, I find that the Claimant is unable to establish, by a preponderance of the evidence, that he is totally disabled due to a respiratory or pulmonary condition. Consequently, he is unable to establish a change in conditions, as is required under § 725.310(2000).

d. Whether the Claimant's Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As set forth above, I also have found that the Claimant is unable to establish that he is totally disabled. Consequently, I must find that the Claimant is unable to establish that he is totally disabled due to pneumoconiosis.

V. CLAIMANT'S MODIFICATION REQUEST

I have reviewed the record in this matter. I find no instance of mistake in determination of a fact in the record compiled to date. I further find that the evidence submitted in the Claimant's current request for modification does not establish any mistake in determination of a fact. The Claimant has specifically asserted that the prior determination, that the Claimant did not have complicated pneumoconiosis, was mistaken (T. at 31-32).

As noted above, I have examined the evidence regarding whether the Claimant has complicated pneumoconiosis, as defined in § 718.304. The Claimant is correct in asserting that there was X-ray evidence of opacities exceeding one centimeter in diameter, submitted in conjunction with his prior request for modification. In his Decision, ALJ Phalen conducted an

exhaustive analysis of the X-ray (and CT scan) evidence. He analyzed the weight of the evidence of each film separately and he determined that, of the seven newly-submitted X-rays, two had evidence of large (size A or larger) opacities. ALJ Phalen also remarked that several of the other X-rays had evidence of the coalescence of opacities. However, ALJ Phalen determined that the radiographic evidence as a whole weighed against a finding of complicated pneumoconiosis. He specifically stated that three most recent X-rays (dated October 15, 2001; October 29, 2001; and February 27, 2002) did not show the presence of large opacities. Additionally, ALJ Phalen noted that four of the five CT scans he considered had evidence of simple pneumoconiosis, and none showed evidence of large opacities. Based on the evidence before him, ALJ Phalen concluded that the Claimant had not established that he had complicated pneumoconiosis.

I find that there is no mistake in determination of fact in ALJ Phalen's conclusion that the Claimant did not establish that he had complicated pneumoconiosis, as defined in § 718.304. I also find, on review of the entire record, that there has been no mistake in determination of a fact during the adjudication of the Claimant's claim.

As set forth above, I have examined the evidence submitted in connection with the Claimant's current modification request. I find that there is no change of conditions, as is required under § 725.310(2000), to justify an award of benefits.

VI. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act.

VII. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VIII. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

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Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).